

## Health Law Review

### Managed Care Under Fire

William A. Sarraile, JD\*; Mark F. Tatelbaum, JD\*\*

A recent flurry of activity in terms of litigation and legislation involving the managed care industry has produced mixed results. Common trends among actions include delayed or diminished payment and network termination, breach of fiduciary duty, negligence in plan administration, breach of contract and fraud, and prompt pay among physician cases, among plan member cases, and among regulatory enforcement cases. The results indicate that physicians face an uphill battle in their efforts to sue managed care organizations for financial causes, although they generally fare better if state regulators adopt their cause; plan members are somewhat more successful than providers, particularly in situations where an alleged denial of care results in injury; by far, the most successful litigant against managed care has been state enforcement agen-

cies, as the states have been particularly successful in actions enforcing their prompt payment regulations.

However, the managed care industry has done well in warding off suits against plan members under the Employee Retirement Income Security Act's pre-emption provisions. Despite the somewhat varying degree of success, it appears that there is a perception among managed care enrollees, providers of care, and state and federal regulators and legislators that the managed care industry is wrongfully enhancing its bottom line at the expense of members' health.

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Recently, the managed care industry has been a popular target for litigation and legislation. Over the past several months, health-care providers, plan members, and regulatory agencies have brought legal actions against managed care organizations throughout the country. Additionally, many states, as well as the federal government, have initiated legislation to regulate the industry further. It seems that on almost a weekly basis another case is filed or a legislative measure is introduced.

The results so far have been mixed. The cases indicate that physicians face an uphill battle in their efforts to sue managed care organizations for financial causes, although they generally fare better if state regulators adopt their cause. Plan members have been somewhat more successful than providers, particularly in situations where an alleged denial of care results in injury. However, the man-

aged care industry has done well in warding off suits against plan members under the Employee Retirement Income Security Act's (ERISA's) pre-emption provisions. By far, the most successful litigant against managed care has been state enforcement agencies. The states have been particularly successful in actions enforcing their prompt payment regulations.

As for legislative efforts, the states, physicians, and plan members have been effective in enacting legislation that increases regulation over managed care organizations and affording plan members greater redresses for a managed care organization's wrongful conduct. The federal government has been less effective. On the federal side, matters have been tied up in committees, and legislation is not likely to be enacted prior to the next presidential elections.

#### PHYSICIAN CASES

Cases brought by providers for financial reasons typically stem from a managed care organization's alleged refusal to pay or failure to pay in a timely manner. These cases are typically brought on a breach of contract theory or violation of state law. Other common cases stem from a provider's alleged wrongful termination from a managed

From Arent Fox Kintner Plotkin & Kahn, PLLC, Washington, DC. \* William A. Sarraile is a partner in the Health Law Group of Arent Fox. \*\* Mark F. Tatelbaum is an associate in the Health Law Group of Arent Fox. Address correspondence: William A. Sarraile, JD, 1050 Connecticut Avenue NW, Washington, DC 20036-5339, Email: sarrailew@arentfox.com.

care preferred provider network.

### ***Delayed or Diminished Payment***

For example, on April 18, 2000, the Medical Association of Georgia and three local doctors filed proposed class-action lawsuits for slow claims payments against Prudential Healthcare, Inc.; United Healthcare of Georgia, Inc.; and Coventry Healthcare of Georgia, Inc. These lawsuits allege that the three health plans routinely delay payments in violation of Georgia law and physician contracts.

While a decision has not yet been rendered in this case, the parties in a similar case in Florida appear to have reached an out-of-court settlement. On February 25, 2000, the Florida Medical Association and Humana, Inc., outlined an agreement to resolve a dispute over alleged downcoding. In this dispute, providers alleged that Humana routinely downcoded physician requests for reimbursement in order to reduce medical costs, while Humana asserted that the downcoding was appropriate because providers were improperly submitting inflated or incomplete reimbursement requests.

### ***Network Termination***

In a recent and much watched network termination case in California, a physician won a big victory. On May 8, 2000, the California Supreme Court held that managed care plans with substantial market power must afford physicians fair procedures, e.g., a hearing process, even if the network participation agreement contained a "without cause" termination provision. In reaching this holding, the Court concluded that the relationship between insurers and their preferred provider physicians significantly affects the public interest such that the California common law right to a fair process applies. The Court's ruling does not necessarily grant a "fair hearing" in every case, however. A network physician's right to common law fair processes is required only where an insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician, to practice medicine or a medical specialty in a particular geographic area, and thereby affect an important substantial economic interest.

## **PLAN MEMBER CASES**

Plan members have brought cases on a variety of different theories. For instance, plan members have brought cases based on a breach of fiduciary duty owed them by

their managed care organization, negligence in administering the plan, and breach of contract and fraud.

### ***Breach of Fiduciary Duty***

Many of the breach of fiduciary cases have been brought under ERISA. Under ERISA managed care organizations have a fiduciary duty to administer their health plans solely in the interest of their enrollees. These lawsuits frequently allege that the managed care organization has put its financial interest above the interest of its enrollees, often resulting in the denial or delay of care and injury to the enrollee. Some of these cases have been successful, while others have not. The case of *Pegram v. Herdrich* that was brought under this theory is currently awaiting decision in the United States Supreme Court.

In *Pegram*, the plaintiff alleged that the presence of financial incentives to her health maintenance organization's (HMO's) physicians breached the organization's fiduciary duty to her under ERISA. The case was argued before the United States Supreme Court on February 23, 2000. A decision is expected shortly.

Another case involving financial incentives under ERISA was settled on March 20, 2000. In this case, Harris Methodist Health Plan agreed to pay \$4.7 million to end a class-action lawsuit alleging that the plan's HMOs failed to disclose financial arrangements with physicians that could limit medically necessary care.

Still other cases brought on similar grounds have not been as successful. For example, on February 16, 2000, a federal court in Nebraska dismissed a lawsuit that United Healthcare Insurance Co. breached its fiduciary duties by charging plan participants a copayment that was 10% above the service contract rate between United and health-care providers. Additionally, on January 4, 2000, a federal court in Texas held that secret compensation arrangements between physicians and HMOs need not be disclosed to plan members.

### ***Negligence in Plan Administration***

In at least one case, a plaintiff has been allowed to proceed against a managed care organization for its alleged negligence in administering its plan. On March 22, 2000, a New York State judge refused to dismiss a lawsuit that charges Aetna U.S. Healthcare with negligently delaying coverage for inpatient substance abuse rehabilitation. The suit posits that the plan member was subjected to a series

of bureaucratic delays, errors, and abuses in his efforts to obtain coverage, and that the plan did not approve his coverage until after he had been dead for 8 days.

In finding the negligence claims triable, the judge said that the plaintiff alleged in sufficient detail incidents of significant, apparently unwarranted delay and confusion which, if proven, may be found by the trier of fact to give rise to an inference of reckless disregard for the decedent's health and well-being. The judge stated further that, in the context of a consumer who has purchased a health care policy with an HMO and who then finds himself or herself requiring treatment, the HMO should be held to a high standard in the manner in which it executes its contractual obligations. The court held that decisions on applications should be expeditiously made, and reviews of those decisions on internal appeal should be resolved quickly. The judge stated that this is particularly true when the consumer needs immediate hospitalization or admission to a health-care facility.

### ***Breach of Contract and Fraud***

In addition to lawsuits alleging breach of fiduciary duty and negligence, plan members have also sued managed care organizations for breach of contract and fraud. These cases typically stem from a managed care organization's alleged denial of treatment.

For example, on January 4, 2000, in a case brought by a plan member, a state jury in Florida ordered Humana Health Insurance Co. of Florida to pay nearly \$80 million to a 9-year-old girl with cerebral palsy for improperly terminating her from special treatment for catastrophically ill patients. The lawsuit charged Humana with breach of an insurance contract, fraud in the inducement, bad faith action, intentional infliction of emotional distress, and promissory estoppel.

Additionally, on January 31, 2000, United Healthcare Corp. was named in a class-action lawsuit based on its termination of Children's Hospital of New Orleans from its provider network. The plaintiffs in this lawsuit allege that the termination of Children's from the network in the middle of their contracted enrollment period, and consequently the specialists associated therewith, wrongfully denies plan members access to contractually promised pediatric care.

## **REGULATORY ENFORCEMENT**

At the same time that managed care organizations are facing litigation from providers and plan members, they have also been subject to enforcement actions by states. Many of these actions have been based on alleged violations of prompt-pay provisions and accountability for downstream-risk arrangements. Additionally, at least one state has also brought suit under ERISA alleging breach of fiduciary duty owed its residents.

### ***Prompt Payment***

Georgia is one of the more aggressive states in enforcing its regulations. For example, on March 2, 2000, the state of Georgia fined Principal Health Care of Georgia, Inc., \$262,700 for not paying claims promptly. In so doing, the Georgia Commissioner of Insurance stated that he is determined to force HMOs to comply with the state's laws on timely payments, and that this was the first fine resulting from that directive. Additionally, in February 2000, the state of Georgia fined United HealthCare of Georgia, Inc., \$123,500 for similar reasons and for not responding quickly enough to consumer complaints. In December 1999, Aetna-U.S. Healthcare of Georgia, Inc., was fined \$50,000 for raising its rates without approval.

Maryland is another state that has been active in enforcing its managed care regulations. For instance, on December 29, 1999, the Maryland Insurance Commissioner ordered United HealthCare of the Mid-Atlantic to pay outstanding claims to downstream providers or face a \$1,000-a-day administrative penalty. The claims at issue illustrate the Maryland Insurance Administration's concerns regarding downstream-risk arrangements.

While Maryland has sought to hold managed care organizations liable for their downstream risk providers, California has not. On January 6, 2000, a California court ruled that a managed care plan is not liable for the failure of an intermediary to which it made capitation payments for the intermediary's failure to pay claims of providers promptly or, for that matter, at all. In a case brought by the California Medical Association against Aetna U.S. Healthcare, the judge agreed with the Department of Corporations that the managed care plan's obligation to pay physicians within a certain number of days was discharged when the plan made capitation payments to the interme-

diaries.

### ***Breach of Fiduciary Duty***

At least one state has followed the lead of plan members and has filed suit against a managed care organization for breach of fiduciary duty under ERISA. On December 14, 1999, the state of Connecticut filed suit against Physician Health Services on this ground. The Connecticut Attorney General alleges that the company's pharmaceutical policies pose potentially harmful and dangerous restrictions on consumers. The Connecticut Attorney General has accused the company of coercing doctors, complicating appeals, concealing information, and pressuring people to switch from drugs originally prescribed by doctors in order to favor the drugs included on its list of covered pharmaceuticals for which it received discounts.

## **LEGISLATIVE INITIATIVES**

Many states, as well as the federal government, have been active in developing legislation to more appropriately regulate the managed care industry. Much of this legislation focuses on giving plan members greater recourse to contest decisions of their managed care plans, and on giving state agencies more oversight authority. The legislation rarely, if at all, affords physicians similar benefits.

### ***State Legislation***

The states have generally been more effective than the federal government in passing managed care legislation. For example, in the past several months alone, New Jersey, New Hampshire, Arizona, New York and Oklahoma passed legislation increasing the rights of providers and/or plan members.

In a victory for providers, on April 6, 2000, New Jersey Governor Christine Todd Whitman signed into law the New Jersey Insolvent HMO Fund Act of 2000. This law will enable doctors to recover two thirds of the estimated \$150 million left behind by the HIP Health Plan of New Jersey and American Preferred Provider Plan before they became insolvent. Funds for these payments will come from 16 New Jersey HMOs, which are required to pay \$50 million over a 3-year period, and from the state, which will contribute \$50 million from money it receives under the national tobacco settlement. This victory for providers may be short-lived, however. The HMO industry has indicated that it will challenge the law on constitutional grounds.

The New Hampshire HMO Accountability Act is an example of legislation that increases the rights of plan members. Enacted on March 7, 2000, this law includes requirements that HMOs set up internal grievance procedures capable of handling complaints within 72 hours, provision for appeals to independent review panels set up by the state insurance commissioner, a ban on contracts containing incentives for doctors to deny care, protection against reprisal for doctors who advocate for patients, and a requirement that utilization review companies hire medical directors.

Similarly, on April 24, 2000, Arizona's governor signed legislation giving HMO members a more independent review process for their claims disputes with their health plans. The bill passed the Arizona legislature by a vote of 48-9 in the House of Representatives and 30-0 in the Senate. The law is a companion to another HMO reform bill that became law on March 23, 2000. This second law gives patients the right to sue their HMOs and mandates increased oversight responsibility by the state's Department of Insurance.

Additionally, on February 7, 2000, the New York Assembly passed a health-care bill that, if passed by the Senate and signed by the Governor, would hold health-care plans legally liable for wrongful denial or delay in treatment. This bill was one of six bills further regulating the managed care industry in New York.

Further, on February 29, 2000, the Oklahoma House passed a bill in a 93-8 vote that would grant patients the right to sue their HMO or managed care organization under a negligence-type basis. Among other things, the bill holds that HMOs and managed care organizations have a duty to exercise ordinary care when making health-care treatment decisions and allows them to consequently be sued for monetary damages if injuries to any patient are proximately caused by the failure to exercise ordinary care. Further, the bill would hold the HMO or MCO accountable for harm that is proximately caused by the health-care treatment decisions made by its employees, agents, ostensible agents, and representatives who are acting on its behalf and over whom it exercises influence and control.

### ***Federal Legislation***

While many states have been active implementing legislation, the federal government has been busy attempting to resolve differences through its own managed care re-

form legislation.

In April 2000, the House-Senate Conference Committee assigned to merge the House (H.R. 2990) and Senate (S. 1344) managed care reform bills continued its attempts to reach agreement on the basic elements of an external appeals process for patients who receive adverse health claim determinations.

The group tentatively agreed that aggrieved patients who have exhausted their health plan's internal review process may appeal to an external reviewer, which would be chosen by an independent review entity that contracts with a health plan. Access to external review would exist, however, only if the cost of the sought treatment exceeded a "significant financial threshold" or if the patients' life or health were in danger.

Additionally, the appeal provision stipulates three major conditions under which a patient would have access to the external review mechanism:

- ◆ the plan determines that there is a lack of medical necessity or appropriateness;

- ◆ the plan determines that the treatment is experimental or investigational; or
- ◆ the plan denied the claim because it did not deem the treatment to be covered under its terms.

The conferees still must remedy the two bills' differences in the divisive areas of scope of coverage and liability, in addition to other issues including tax provisions and health insurance access provisions.

## CONCLUSION

Thus, as can be seen from these court cases and legislative initiatives, managed care is currently under attack on many different fronts. These attacks seem to indicate a widespread dissatisfaction with the managed care system. There appears to be a perception among managed care enrollees, providers of care, and state and federal regulators and legislators that the managed care industry is wrongfully enhancing its bottom line at the expense of its members' health. If this perception continues, be it correct or incorrect, the managed care industry will likely continue to fall under fire.